

MAIL TO:
E.D.S. FEDERAL CORPORATION
PRIOR AUTHORIZATION UNIT
6406 BRIDGE ROAD
SUITE 88
MADISON, WI 53784-0088

AUDIOLOGICAL PRIOR AUTHORIZATION REQUEST FORM

PA/ARF1

(DO NOT WRITE IN THIS SPACE)

ICN #
A.T. #
P.A. # 1234567

1. PROCESSING TYPE

123

2. AUDIOLOGICAL CENTER NAME I.M. PROVIDER		3. PROVIDER NO. 12345678		4. REQUESTING AUDIOLOGIST NAME/NO I.M. REQUESTING 12345678	
5. CENTER ADDRESS 1 W. WILLIAMS ANYTOWN, WI 53725		6. CENTER TELEPHONE NO. (XXX) XXX-XXXX			
8. RECIPIENT'S MEDICAL ASSISTANCE I.D. NUMBER: 1234567890		7. REFERRING PHYSICIAN NAME/NO. I.M. REFERRING 12345678			
9. RECIPIENT'S NAME (LAST, FIRST, MIDDLE INITIAL) RECIPIENT, IMA		11. DATE OF BIRTH MM/DD/YY		12. SEX M <input type="checkbox"/> F <input checked="" type="checkbox"/>	
10. RECIPIENT ADDRESS: 609 WILLOW ANYTOWN, WI 53725		13. DIAGNOSIS: 389.10 SENSORINEURAL HEARING LOSS			

14 POS	15 TOS	16 PROCEDURE CODE	17 TYPE OR LIKE MODEL	18 QUANTITY	19 CHARGES
3	P	W6901	STANDARD HEARING AID	1	XX.XX
3	P	V5090	HEARING AID DISPENSING	1	XX.XX
				TOTAL CHARGES	20 XX.XX

An approved authorization does not guarantee payment.

Reimbursement is contingent upon eligibility of the recipient and provider at the time the service is provided and the completeness of the claim information. Payment will not be made for services initiated prior to approval or after authorization expiration date. Reimbursement will be in accordance with Wisconsin Medical Assistance Program payment methodology and Policy. If the recipient is enrolled in a Medical Assistance HMO at the time a prior authorized service is provided, WMAP reimbursement will be allowed only if the service is not covered by the HMO.

21. MM/DD/YY
DATE

22. *J M. Requesting*
REQUESTING AUDIOLOGIST SIGNATURE

(DO NOT WRITE IN THIS SPACE)

AUTHORIZATION:

☐
APPROVED

☐
MODIFIED — REASON:

☐
DENIED — REASON:

☐
RETURN — REASON:

GRANT DATE

EXPIRATION DATE

PROCEDURE(S) AUTHORIZED QUANTITY AUTHORIZED

DATE

CONSULTANT/ANALYST SIGNATURE